304.17A-625 Factors to be considered by independent review entity conducting external review -- Basis for decision -- Insurer's responsibilities -- Contents, admissibility, and effect of decision -- Consequence of insurer's failure to provide coverage -- Liability -- Written complaints.

(1) In making its decision, an independent review entity conducting the external review shall take into account all of the following:

(a) Information submitted by the insurer, the covered person, the authorized person, and the covered person's provider, including the following:

1. The covered person's medical records;

2. The standards, criteria, and clinical rationale used by the insurer to make its decision; and

3. The insurer's health benefit plan;

(b) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the National Institutes of Health, or any board recognized by the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, and the United States Food and Drug Administration, the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services, and the Agency for Health Care Research and Quality; and

(c) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical specialists, and clinical guidelines adopted by relevant national medical societies.

(2) The independent review entity shall base its decision on the information submitted under subsection (1) of this section. In making its decision, the independent review entity shall consider safety, appropriateness, and cost effectiveness.

(3) The insurer shall provide any coverage determined by the independent review entity to be medically necessary. The independent review entity shall not be permitted to allow coverage for services specifically limited or excluded by the insurer in its health benefit plan. The decision shall apply only to the individual covered person's external review.

(4) Nothing in this section shall be construed as requiring an insurer to provide coverage for out of network services, procedures, or tests, except as set forth in KRS 304.17A-515(1)(c) and 304.17A-550.

(5) The insurer shall be responsible for the cost of the external review.

(6) The independent review entity shall provide to the covered person, treating provider, insurer, and the department a decision which shall include:

(a) The findings for either the insurer or covered person regarding each issue under review;

(b) The proposed service, treatment, drug, device, or supply for which the review was performed;

(c) The relevant provisions in the insurer's health benefit plan and how applied; and

(d) The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

(7) The decision of the independent review entity shall not be made solely for the convenience of the insurer, the covered person, or the provider.

(8) Consistent with the rules of evidence, a written decision prepared by an independent review entity shall be admissible in any civil action related to the adverse determination. The independent review entity's decision shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

(9) The decision of the independent review entity shall be binding on the insurer with respect to that covered person. Failure of the insurer to provide coverage as required by the independent review entity shall:

(a) Be a violation of the insurance code of a nature sufficient to warrant the commissioner revoking or suspending the insurer's license or certificate of authority; and

(b) Constitute an unfair claims settlement practice as set forth in KRS 304.12-230.

(10) Failure to provide coverage as required by the independent review entity shall also subject the insurer to the provisions of KRS 304.99-010 and 304.99-020 and require the insurer to pay the claim that was the subject of the external review, without need for the covered person or authorized person to further establish a right as to the payment amount. Reasonable attorney fees associated with the actions of the insured necessary to collect amounts owed the covered person shall be assessed against and borne by the insurer.

(11) The insurer shall implement the decision of the independent review entity whether the covered person has disenrolled or remains enrolled with the insurer.

(12) If the covered person has been disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was previously denied by the insurer, its agent, or designee and later approved by the independent review entity for a period not to exceed thirty (30) days.

(13) Within thirty (30) days of the decision in favor of the covered person by the independent review entity, the insurer shall provide written notification to the department that the decision has been implemented in accordance with this section.

(14) An independent review entity and any medical specialist the entity utilizes in conducting an external review shall not be liable in damages in a civil action for injury, death, or loss to person or property and is not subject to professional disciplinary action for making, in good faith, any finding, conclusion, or determination required to complete the external review. This subsection does not grant immunity from civil liability or professional disciplinary action to an independent review entity or medical specialist for an action that is outside the scope of authority granted in KRS 304.17A-621, 304.17A-623, and 304.17A-625.

(15) Nothing in KRS 304.17A-600 to 304.17A-633 shall be construed to create a cause of action against any of the following:

(a) An employer that provides health care benefits to employees through a health benefit plan;

(b) A medical expert, private review agent, or independent review entity that participates in the utilization review, internal appeal, or external review addressed in KRS 304.17A-600 to 304.17A-633; or

(c) An insurer or provider acting in good faith and in accordance with any finding, conclusion, or determination of an Independent Review Entity acting within the scope of authority set forth in KRS 304.17A-621, 304.17A-623, and 304.17A-625.

(16) The covered person, insurer, or provider in the external review may submit written complaints to the department regarding any independent review entity's actions believed to be an inappropriate application of the requirements set forth in KRS 304.17A-621, 304.17A-623, and 304.17A-625. The department shall promptly review the complaint, and if the department determines that the actions of the independent review entity were inappropriate, the department shall take corrective measures, including decertification or suspension of the independent review entity from further participation in external reviews. The department's actions shall be subject to the powers and administrative procedures set forth in subtitle 17A of KRS Chapter 304.

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